

United States District Court Southern District of Texas

Case Number: H-04-2387

ATTACHMENT

Description:

☐ State Court Record ☐ State Court Record Continued

☐ Administrative Record

☐ Document continued - Part II of IV

☒ Exhibit(s) number(s) / letter(s) # 102

Other: Pliff's First Amended Petition
Habeas Corpus

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1 this as being something that they were hired to do. I don't
2 know how many times I read grievance reports that said, Take
3 your problem to the major. One of the biggest problems that I
4 found in administrative segregation particularly is that an
5 inmate can't see a major. Very often does everything in his
6 power to get the major to come see him so he can talk to
7 someone. I guess what I am sharing with you is this absence,
8 this almost total void of anybody who tries to help that inmate
9 do what he should and can do with that kind of an assistance.
10 And what you have over here with the correctional officers,
11 their role is to control and they will control in whatever way
12 they feel it's necessary.

13 Q. What impact do you think it has on the relationship between
14 the prisoner who has perceived needs and the correctional
15 officer who may not have time or inclination to try to meet
16 those needs? What impact do you think the absence of the
17 classification counselors or any substitute has on the

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18 interaction between inmate and the correctional officer?
19 A. In prisons -- I visited at one time every major prison in
20 the United States, but in prisons they're called by different
21 names and for purposes here generically we'll say classification
22 counselor. The classification counselor is the bridge between
23 custody and the inmate. There are some very, very good
24 correctional officers that are out there that want to do the
25 right thing. Classification counselors have helped them,

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1 advised them, shown them how this can be done, sort of act as
2 the intermediary in terms of how correction officers get along
3 with inmates. With the void that exists now, it very often
4 unfortunately becomes a case of we against them and the inmate
5 body sees the correctional officer as they call them, the cops,
6 the police. They are not people that they can turn to, in their
7 minds, for help.

8 Q. Did you have any observations of a systemwide nature about
9 the situation with prisoners trying to get the major's attention
10 or the attention of other kind of rank, what kind of conflict
11 that created in the system?

12 A. I would ask you to just build on that a little so I'm sure
13 that I understand.

14 Q. Well, what's jacking in a slot? What's jacketing a slot?

15 THE COURT: What is what?

16 MS. BRORBY: Jacking a lot. Jacking a food slot.

17 THE COURT: I still don't understand.

18 THE WITNESS: I would really ask counsel not to use
19 inmate jargon, because I think it's confusing to everybody,
20 including the record. Just ask me the question and I'll answer.

21 BY MS. BRORBY:

22 Q. Have you observed in any of the use of force reports,
23 reports of a situation that starts with an inmate extending his
24 arm through a food slot in a segregated situation and force
25 ensuing?

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1 A. There is innumerable -- and if anybody doubts this, they
2 just merely need to go review any two months' use of force
3 reports. So many of them begin with the fact that an arm or a
4 towel or something is put outside the food slot so that it can't
5 be closed.

6 Q. And did you learn why arms were sticking out of food slots?

7 A. Nine times out of ten the only reason is that the inmate
8 has some hope that he can talk to rank. Somebody above a
9 correctional officer. And he's willing to take the serious
10 consequences of what he's doing, because he knows that if he
11 leaves it out there, that what they're going to do eventually is
12 come in, gas him, bring an extraction team in, all for the
13 purpose of closing food slot.

14 Q. Did you observe similar conflict where inmates were
15 purporting anyway to attempt to speak to rank by withholding
16 food trays in their cell in administrative segregation?

17 A. There's always a difference of opinion - and that's

18 understandable - why inmates do some of the things they do. I
19 would have to, and in my opinion, conclude that the majority of
20 cases that I reviewed were efforts on the part of the inmate to
21 talk to someone and they saw this as a method of doing it.

22 One case that came to my attention -- I wasn't there
23 personally, but I reviewed the incident report. This particular
24 inmate had climbed up the side of the cages on the windows until
25 he was some 20, 25 feet above the ground, refused to come down.

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1 He was ordered to come down and didn't. It happened to be that
2 there was a central office assessment team visiting that same
3 day and they came in and the psychologist that was a part of
4 this team then talked the inmate down. I'm using this as an
5 example, because in most cases if inmates are given the
6 opportunity to talk about what it is that they're trying to
7 demonstrate by inappropriate behavior, you can bring about a
8 reasonable responsible kind of solution.

9 Q. Did you have any observations about how usual or unusual it
10 was to have that kind of event where there was some serious
11 talking about a problem before force was invoked as a method to
12 avoid force?

13 A. I found, and in this case it had to be based on the record,
14 or based on, and it would still be the record, and that is the
15 use of cameras with the -- with the audio opportunity to hear
16 what has occurred.

17 One case might illustrate best a situation of that

18 kind. The inmate was in the rec area and wouldn't leave. He
19 stated when officers demanded that he come out that he would
20 leave if the major would come and talk to him. After a good
21 deal of verbal exchange back and forth, the major came with a
22 five point -- I mean, a five-person extraction team. The major
23 made no effort on the record, nor did in reviewing the audio
24 section of the camera film make any effort to do other than, You
25 are ordered to put your hands out through the port. That was

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1 done three times. But there was no effort that was -- that I
2 was able to identify that the major said, I'll talk to you.
3 I'll listen to you. It's -- it's a willingness and it's the
4 best thing in terms of staff protection that I can think of is
5 you exhaust everything you can to see if you can't find a
6 solution short of using force.

7 BY MS. BRORBY:

8 Q. Did you see in the documentation you reviewed more than one
9 case like the one you just described where before gas was used
10 the only verbal interaction was to order the inmate to do
11 whatever he was being ordered to do and tell the inmate that if
12 he didn't do it he would be gassed?

13 A. Yes, I -- and I don't know how the Court wishes to use
14 identification of inmates. I've shared both names and numbers
15 with parties. I always hesitate to ever use a name.

16 THE COURT: Just use the number, will be all right.

17 THE WITNESS: Okay. An example -- in this particular

18 case the inmate was in ad seg day room. He refused -- he also
19 refused to come out. He asked to speak to rank. The team came.
20 The major also came. Refused to talk to him. A 37-millimeter
21 gun was fired five times. The inmate was subdued, claims that
22 he was kicked in the eye by the sergeant during the process.
23 The medical report indicated that there was retina bruising,
24 vision went from 20/20 down to 2200. He grieved the incident,
25 was denied. He had a past history of use of force under the

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1 certain -- same kinds of circumstances. One of the occasions
2 his head was kicked, he had seven stitches in his head. I could
3 give you many other examples of use of gas and then resulting
4 force. In no case was there a danger to the institution at that
5 time. At no case was there a danger to that inmate or to staff
6 when an extreme use of force was precipitated.

7 Q. In those cases -- in any of those cases that you're
8 referring to was there a documented attempt, either in the
9 videotape or in the use of force reporting to have -- to engage
10 the inmate in a substantive discussion with whatever the
11 inmate's problem was that was causing him to be recalcitrant and
12 not move under threat of gas?

13 A. As I indicated earlier, I could find none. I am not saying
14 that it never occurred. I'm saying that there is no
15 documentation. And having been an old medical accreditation
16 person in the field of corrections, I've been informed and
17 taught by doctors that if it isn't in the record, it didn't

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18 happen.

19 Q. In addition to the kind of incident that you have been
20 describing with the use of chemical agents on prisoners in
21 confined settings when there is no risk posed and no apparent
22 attempt to use alternatives to force, are there other examples
23 that you can share with us of the kind of wrongful force that
24 you found on a systemwide basis in the Texas Department of
25 Corrections?

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1 A. Yes. And I'll try to do this very quickly. As I say, I
2 picked out cases that aren't unusual. These are cases, though,
3 that represent occurrences in all kinds of units and with both
4 genders. The first case is 474317. This is a young woman who
5 was handcuffed. She was hit in the face and with her arms
6 handcuffed behind her back they were jerked up, breaking her
7 upper arm. 72 hours ad seg even before she was taken to a
8 hospital. She filed a grievance. An IA was involved and no
9 fault was found at any point.

10 Another case of a woman, 620484, she passed a letter
11 to another inmate, was seen. The two of them were taken inside
12 and strip searched. The letter was given to them. One inmate
13 was allowed to go, the second was asked to be strip searched
14 again and a digital observation or search made. She refused.
15 She was taken to the infirmary and for several hours stood
16 against the wall and observed, all times handcuffed. She was
17 then put on a gurney with her arms handcuffed -- hands

18 handcuffed behind her back. Her clothes were cut off, and a

19 lieutenant made both a vaginal and a rectum digital search.

20 There was a nurse present. The nurse refused to make the

21 examination and did not have any part in it.

22 I cite this case regardless of the Department of

23 Corrections perhaps coming back and saying it's permissible to

24 have correctional officers make such searches, but I am sure --

25 I am absolutely sure that there was no intention in developing

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1 that policy to ever have it applied to female offenders with
2 vaginal searches made by untrained personnel.

3 Another case. This is a man who had been with the
4 Gang 7 since 1989 and he was locked up in ad seg because of it.

5 Q. Do you have his number?

6 A. I was going to give it at the end, but 490569. He was
7 taken to the shower area under restraint and placed -- and they
8 call it a legal cage, but a small cage right next to the shower
9 area, waiting his turn. There's no question that he was talking
10 loudly and was told a number of times to keep quiet, but he
11 didn't, so the officer opened the cage, rammed him against the
12 back of the cage, tried to throw him to the floor by himself,
13 was unable to. The inmate held on to the small table inside the
14 cage and then four or five officers came and forced him to the
15 floor and put him in restraints. He was taken to the hospital
16 with injuries. He was charged with striking an officer. I
17 indicate this case because he was under restraint, he could not

18 strike the officer and he was under total control until the
19 officer independently and by himself opened that cage.

20 The next case, 636644. This is an inmate in October
21 of '96 who was being escorted to the shower. He was in
22 administrative segregation. He's in boxer shorts, in shower
23 shoes. Otherwise naked. He was handcuffed behind his back.
24 There was no soap in the shower and he asked for it. I'm sure
25 that he didn't ask for it appropriately. He was told there

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1 wasn't any soap and they weren't going to get it. I'm sure that
2 there was a good deal of verbal confrontation. But as a result,
3 he was slammed to the ground, became unconscious, was finally
4 taken to the infirmary, where it was found that he had a serious
5 laceration to his chin and a broken jaw. I emphasize this case
6 because he's under constraint. He's certainly not in fighting
7 clothes at the time. There was no reason for him to try to
8 accomplish anything. And although he may have been - I do not
9 know this - verbally abusive, there was no protection needs for
10 the serious damages that resulted.

11 Another case, 531735. This inmate had been -- this
12 inmate had had a mastectomy just five days before this incident
13 and had his left arm in a sling with --

14 THE COURT: Before --

15 THE WITNESS: -- the stitches still in.

16 THE COURT: Before we go forward with this incident,
17 we'll have the noon hour recess. The Court will be in recess

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18 for one hour.

19 (Recess at 12:00 p.m., until 1:00 p.m.)

20 THE COURT: You may resume your direct examination.

21 MS. BRORBY: Thank you, Your Honor.

22 CONTINUED DIRECT EXAMINATION

23 BY MS. BRORBY:

24 Q. Mr. Breed, when we broke for lunch you had just begun

25 discussing the case involving the prisoner with the number

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1 531735. Is that the case of Mr. Batiste?

2 A. Yes.

3 THE COURT: Is this the broken jaw case?

4 MS. BRORBY: Your Honor, this is the mastectomy case.

5 BY MS. BRORBY:

6 Q. This is Mr. Batiste, I think.

7 A. That's correct.

8 Q. Who actually testified before the Court about that

9 incident.

10 A. Since the inmate has had the opportunity to testify and

11 present his case, I won't go into any detail other than the fact

12 that obviously an injured inmate, who was in no position to be a

13 threat, after he was restrained and put on the ground was kicked

14 in the ankle, which was broken, and it was five days before even

15 a cast was applied. I think the important aspect of this case,

16 though, is that he submitted a grievance, which was denied. He

17 was charged with staff assault and went from an S-4 to an L-1,

18 plus 15 days of solitary. The warden signed off on this case

19 and the IAD did not investigate the case.

20 The next one I would like to share, is this is an

21 inmate that was being - and I'll get the number and the name -

22 was being escorted to the shower under restraint. He, in the

23 report by the officer, was moving too slowly and the officer

24 slammed him into a sliding metal door. The officer claims the

25 inmate wouldn't move fast enough and he was forced to use that

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1 kind of force. As a result, there were eight staples placed in
2 the laceration to the head, bruises to the shoulder. He was
3 found guilty of trying to pull away from an officer while under
4 restraint. No action was taken by the warden or the Internal
5 Affairs. It's interesting, however, that -- on this case
6 705122.

7 The next case was during a shakedown. The inmate
8 obviously was loud and abusive. The sergeant claims that the
9 inmate turned aggressively towards him. The inmate claims that
10 he was grabbed by the back of the neck. Regardless of who's
11 right, he was slammed into the edge of the shower door several
12 times with five stitches required to the head. The officer in
13 his statement said he was guided to face the shower door and
14 struck his head on the metal door. The warden found no fault
15 with the sergeant, however, he did reprimand the officer for
16 failing to ensure that the camera was on wide angle.
17 Q. Was that inmate restrained?

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18 A. Yes. The last case, and I have many, but I think this is
19 enough to give examples, was an inmate who wouldn't give the
20 officer his homemade cap. He was put into restraint and
21 allegedly jerked free of the hold that they had on him. By the
22 reported self, there were a number of officers there at the
23 time. He was placed on the floor and was badly beaten. He had
24 a laceration to the left eyebrow, right eye was punctured --
25 ruptured, cut to the chin, contusions to the cheek. All of this

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1 on a five-foot-eight-inch, 130-pound inmate who is hardly a
2 threat.

3 Two other things about this case that I would like --

4 Q. Is that really five foot eight inches?

5 A. Five foot eight inches and 130 pounds.

6 I would like to share, though, also, that on this
7 particular case there were 24 inmates who were listed as
8 refusing to give a statement. I found this on many, many cases
9 - this one, as many others that I did as well - I went to check
10 with inmates that allegedly had refused to make a statement.
11 Out of the 24 I was able locate six, all stated that they were
12 never asked to give a statement.

13 I think that we'll talk about that more at a later
14 point, but the effort to get statements is a serious problem in
15 being able to determine the facts.

16 Q. Have you --

17 A. Unless Counsel wants more cases, I would think that would

18 be sufficient to indicate the area.

19 Q. In the course of the work that you described earlier during
20 your testimony, have you had occasion to investigate the issue
21 of use of force in systems or institutions outside of TDCJ?

22 A. Yes, I have. In almost every prison and jail case, one of
23 the conditions to which I was responsible for monitoring was
24 excessive use of force. One of the things that I was
25 disappointed in finding in Texas, because I had every hope that

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1 that condition had been addressed with the addition of
2 additional officers, was that there was so much use of force in
3 greater amounts and in greater degree of the excessiveness that
4 I found here than I found in any other state system that I have
5 looked at.

6 Q. Let's move on to the formal policies and procedures
7 concerning the process that has been or will be further
8 described by the witnesses for addressing use of force in the
9 system, a process for complaints for use of force and
10 investigation of uses of force.

11 A. I was impressed initially when I reviewed the policies and
12 procedures in the department, because I thought in most cases
13 they were very good, but what they really require is a great
14 deal of paperwork, and even the paperwork is not functioning
15 adequately.

16 Let me go through them rather rapidly. But the first
17 thing that happens with the use of force is that the officer who

18 is responsible for the use of force has to make out a report.
19 Now, as I indicated earlier, I reviewed over 500 of these use of
20 force reports, and my estimate is that well over 70 percent of
21 those clearly showed excessive force being used. You have to
22 remember, however, that this report includes officer's
23 perspective of what happened, nothing more. It's the officer's
24 perspective. Secondly, witnesses sometimes extensively -- I'm
25 surprised at the number of officer witnesses that evidently were

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1 a part of the use of force by the number that are in each
2 packet. They are almost verbatim to what the officer who
3 initially used force stated. You get the impression, at least,
4 that peers take a look at what the original incident report said
5 and then they make a very similar kind of comment.

6 Q. Is that unusual in your experience in your investigations
7 of the use of force in other systems?

8 A. It's not unusual because I think you will always find that
9 within the fraternity of correctional officers, they're going to
10 support each other. But the fact that there are three other
11 witnesses, correctional officers who are peers who say exactly
12 the same thing as the reporting officer raises questions.
13 Particularly in view of the fact that it is required as part of
14 the report that there be an inmate statement.

15 Now, of all of the cases that I reviewed, less than
16 five percent of them had inmate statements. What they do have
17 is a requirement that the inmate refused to make a statement and

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18 two officers sign indicating that they are approving that as a
19 submission.

20 I made very strong language in my statement, which I
21 later amended during the deposition. I'm not accusing
22 correctional officers of falsifying records. What I am saying
23 is that it's rather unusual that almost all cases the inmate
24 refuses to make a statement when the next day he puts it down in
25 a grievance. The grievances indicate that the inmate did want

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1 to make a statement and either wasn't allowed to or wasn't
2 allowed the necessary forms.

3 The next thing that concerns me about the use of force
4 report is that there is no investigation made by the supervisor
5 or the middle management level to determine actually what the
6 facts are. I've already indicated that inmate witnesses seldom
7 are used and more often you find this group witness form saying
8 that everybody in that area listed by name refused to make a
9 statement.

10 Now, this package then goes to the warden --

11 Q. Let me stop you for a minute. What makes you think that
12 there is no investigation by a supervisor?

13 A. I have to respond by saying that there is nothing in the
14 file that would indicate there was. I looked very diligently
15 for this. I asked majors, I asked captains, and they said that
16 that was not their responsibility to carry on any form of an
17 investigation, even though that would be part of a supervisor

18 and a manager's responsibility regardless of whether it was use
19 of force or any other incident. That's the first line of
20 defense to get the facts.

21 Q. How does this compare, in your experience, with use of
22 force systems in other prison systems in terms of documentation
23 of a supervisorial investigation into the facts of what
24 happened?

25 A. I have always found, I don't believe that there is any --

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1 any facility or agency, correctional agency, that I have found
2 that didn't put heavy emphasis on first-line supervisors making
3 a thorough investigation of use of force. And, secondly, that
4 that be reviewed very carefully, even to the point of doing
5 additional interviewing by management before it goes to the
6 warden.

7 Q. In your opinion is that an important part of a use of force
8 system in curtailing excessive and unnecessary force?

9 A. If you don't have that in your system from a system
10 standpoint, you are not addressing the way that enforcement of
11 policies and procedures is carried out in every walk of life.
12 This is a systemwide problem that prior to going to the warden
13 there isn't the information that would be necessary for him to
14 make any kind of a valid, reasonable decision.

15 When it gets to the warden, and this is prepaid by a
16 clerical-type person which has a checklist to assure that each
17 one of these reports, witness reports, medical report, et

18 cetera, is in the package, it then goes to the warden and one
19 would assume that the warden would then carry on some kind of an
20 investigation himself or at least would write some kind of a
21 statement, but unless the warden makes a determination that he
22 wants to have a hearing, which is seldom done, all he does is
23 make a check mark saying that he has completed all of the
24 documents that are required by policy, signs it, and sends it on
25 into region and to Huntsville Central.

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1 Q. And how does that level of warden involvement in the review
2 of the use of force compare with other systems with which you're
3 familiar?

4 A. A system that -- any system that I have found that has
5 really tried to address this because it was a problem just in
6 terms of the numbers of cases that were occurring, it becomes of
7 the highest priority for the warden not to just sign a form, but
8 for the warden to know exactly what's happening. If there's any
9 question in his mind, then he or she should carry out additional
10 investigations, either themselves or by someone else that they
11 have the utmost confidence in.

12 Now, in those few isolated cases where I said that the
13 warden did have a hearing, the hearing consists of the officer
14 and any of the officer witnesses coming in and repeating what
15 has already been put into the record in the way of statements.
16 Inmate witnesses do not get called and the inmate against who
17 the force was used is not called.

18 Really about all the warden does at that juncture is
19 either, one, decide that the action was appropriate and closes
20 the matter; two, he might want to let the Internal Affairs
21 department review it, and he would refer it to them; or, three,
22 he himself awards punishment.

23 Now, the second avenue by which an inmate has the
24 opportunity to bring the use of force to the attention of
25 administrators is by filing a grievance. It's interesting to

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1 note that there are more use of force reports coming through the
2 grievance procedure than there is through the official use of
3 reports going up through the line.

4 The grievance officer has a responsibility not to
5 personally investigate. Generally speaking, in talking to
6 grievance officers, they review to see that the paperwork is
7 there. And if the paperwork is there, they're satisfied to send
8 the package on to the warden. If in the eyes of the grievance
9 officers there is some question that he feels it should be
10 answered, then he turns it over to custody and asks for a
11 report.

12 I found few cases in where it was turned over to a
13 management major, captain or lieutenant to review, but in every
14 case in which that procedure was followed, I found that the
15 major or the captain or the lieutenant quoted from the original
16 officer's statement and said that the action was appropriate.

17 The grievance then is returned, denied in every single

18 case around use of force. The inmate does have the right to
19 appeal the grievance to the second level, but I found in no case
20 where it was grieved to the second level did the second level
21 approve of the grievance or in effect ask for anything further
22 in the way of investigation.

23 What the grievance does do, however, and it seems to
24 be sort of the end of the trail, is that they make a referral to
25 the Internal Affairs division.

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1 However, before we speak about that process, let me
2 state that there is no feedback whatsoever from the IAD back to
3 the grievance officer or back to the warden that could be found
4 in any record to indicate whether they accepted the case,
5 whether they opened the case, whether they closed the case
6 administratively, or whether they sustained the case.

7 It would appear to me that the unit level, both
8 grievance and warden, depend upon the IAD as a way of shifting
9 the responsibility for any further investigation to that entity.
10 So the last group would be the IAD. They receive from the
11 warden, from the grievance officer or from outside elements,
12 parents, relatives, sometimes even legislators. It is, however,
13 within their total discretion to whether they even open the
14 case.

15 I would suggest that the number of cases that they
16 open are far fewer than what one would expect if you were having
17 a vigilant group that was overseeing what was happening within

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18 the department. And I think the most --

19 Q. What's your basis for that conclusion?

20 A. Pardon?

21 Q. What is it that makes you think that if they were being

22 more vigilant about the use of force issue in TDCJ that the IAD

23 would open more cases?

24 A. I believe that if it was a requirement, as an example, that

25 the IAD had to report back to the warden on every single case as

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1 to whether or not they were going to open it for investigation,
2 and secondly, if they decided not to, the reasons for their
3 taking that position, which would then also allow the warden a
4 second opportunity to make a decision as to whether or not
5 further investigation should be carried on. It's the sheer
6 numbers of cases that are -- are transferred to the IAD and the
7 relatively small number that are open that brings me to the
8 conclusion that I made.

9 There's a great deal of difficulty for law enforcement
10 personnel to investigate law enforcement personnel. One only
11 has to have even limited experience working with our police
12 agencies across the country and the great difficulty they have
13 with their Internal Affairs groups of getting them to go out in
14 terms of reviewing what their peers are doing, and there is a
15 tendency to always look at it favorably from the standpoint of
16 the officer.

17 However, Texas was very, very wise in setting up their